

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1. a. Whether there should be additional reimbursement for dates of service, 05/11/01 through 07/30/01.
- b. The request was received on 05/07/02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60
  - b. HCFA-1500
  - c. EOBs
  - d. Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 05/29/02. There is no response from the Requestor found in the file.
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

There was no carrier sign sheet noted in the dispute packet. There are no carrier responses in the case file.

### **III. PARTIES' POSITIONS**

1. Requestor: Letter dated 05/06/02:

“These services should be reimbursed as they were medically necessary and ordered by the Treating Physician [sic]. These services were billed correctly according to TWCC fee guidelines. Finally (Carrier) is in direct violation of rule # 133.303, which requires not less than 50% of payment within 45 days and TWCC rule # 134.803, which provides for an interest payment.”
2. Respondent: No Response.

#### IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those beginning on 05/11/01 and ending on 07/30/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the provider's TWCC-60, the provider billed the carrier \$418.00.
4. Per the provider's TWCC-60, the carrier paid the provider \$198.00.
5. Per the provider's TWCC-60, the amount in dispute is \$220.00.
6. Per the provider's Table of Disputed Services, the CPT codes in dispute are 97010 and 97035.

#### V. RATIONALE

Medical Review Division's rationale:

The carrier denied the charges in dispute code "111 – FHN CONTRACT STATUS INDICATOR 02 - NON-CONTRACTOR PROVIDER FHN Message - 0."

When determining whether or not additional reimbursement is warranted, the Medical Review Division must first determine that the services were rendered as billed. After review of the dispute file, no documentation was noted to support the services billed. **No** additional reimbursement is recommended.

The above Findings and Decision are hereby issued this 29th day of August 2002.

Donna M. Myers, B.S.  
Medical Dispute Resolution Officer  
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.